DMAS-353 A
EPSDT SCREENING DOCUMENTATION FORM

(N) = Normal or (-) negative findings. Abnormal or positive findings must be documented

NAME: _____ DOB:_____

AGE/DATE				
HT				
WT				
HC				
T P R				
FORMULA/DIET				
PERTINENT INTERVAL HISTORY				
EXAM				
Oral Inspection				
HEENT				
Chest				
Heart				
Gastrointestinal				
Genitourinary				
Musculoskeletal				
Endocrine				
Skin				
Lab				
Hematology (Hbg/Hct)				
Blood lead				
Urine				
Sickle Cell				
Other				
NUTRITION				
VISION SCREENING				
HEARING SCREENING				
REFER TO DENTIST				
GROWTH AND DEVELOPMENT				
PERTINENT PROBLEMS/EXAM ABNORMALITIES				
IMPRESSION				
HEALTH EDUCATION AND ANTICIPATORY GUIDANCE				
REFERRALS				
PHYSICIAN'S SIGNATURE:				
DATE				
NEXT SCREENING APPT				